HEALTH HERO

Patient Safety Incident Response Policy

Quality & Governance Policy

Department:	Quality	**Version No:**	2
Responsible Executive	Chief Operating Officer	**Review Date:**	21/07/2025
Owner:	Associate Director of Quality	**Next Scheduled Review:**	21/07/2026
Intended Audience:	Internal		
Policy Status:	This policy does not give contractual rights to individual members of staff. The company reserves the right to alter any of its terms at any time, although we will notify you of any changes. For the purposes of these documents, the Company name is referred to as HealthHero. This policy is applicable to the following entities: - ☐ Group ☐ Enterprise IE ☐ Enterprise UK ☒ NHS UK – HealthHero Integrated Care ☐ Doctorlink Document uncontrolled if downloaded or printed		

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Amendments Summary

Version	Section	Amendment Details	Date Issued
1	New policy / plan document	New document created by the Medvivo Quality Team as a result of the Patient Safety Incident Response Framework replacing the previous Serious Incident Framework (2015)	New policy / plan document
2	Throughout	Updated to new template and rebranding form Medvivo to HealthHero Integrated Care – Job titles amended to reflect current structure. Health and Safety incidents now captured on RADAR.	21/07/2025

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1. Introduction

Unlike previous frameworks, the Patient Safety Incident Response Framework (PSIRF) is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond to incidents, in order to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and improvement.

PSIRF sets no national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are now able to balance effort between learning through responding to incidents and exploring issues and improvement work.

Essential to PSIRF is fostering and maintaining a culture in which people feel safe to talk. HealthHero recognises having conversations with people relating to an incident can be difficult and it is vital to support staff, patients, families, and all involved during a patient safety investigation.

The aim of this approach is to continually improve. HealthHero will monitor the impact and effectiveness of implementing PSIRF. HealthHero will respond and adapt as and when the organisation's approach is not achieving what was set out to achieve, as such this document will be reviewed annually.

2. Purpose

This policy supports the requirements of the PSIRF and sets out HealthHero's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Inclusive and compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents

- Considered and proportionate responses to patient safety incidents and safety issues

- Supportive oversight focused on strengthening response system functioning and improvement

3. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across HealthHero Integrated Urgent Care.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an inherent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4. Patient safety culture

HealthHero promotes a just culture[1] approach to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

HealthHero encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or

[1] Just Culture is about creating a culture of fairness, openness and learning in the NHS. This is to make colleagues feel confident to speak up when things go wrong, rather than fearing blame NHS England » A just culture guide

may lead to, harm to patients or staff.
HealthHero is committed to:

- Promoting justifiable accountability with a fair, open, inclusive and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of individual staff but also focuses on the system in which they were working in order to learn lessons
- Improving communication and the development of a mature safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents
- Openness in the handling of patient safety incidents and the application of the Being Open Policy and Duty of Candour

Please refer to the Adverse Incident Reporting, Investigation and Learning Policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

5. Addressing health inequalities

HealthHero will respond to any issues related to health inequalities as part of the implementation of this policy.

Through the implementation of PSIRF, HealthHero will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Executive Team and partner agencies on how to tackle these.

HealthHero's engagement with patients, families and carers following a patient safety investigation must recognise the diverse needs of the populace and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the Being Open and Duty of Candour process.

6. Engaging and involving patients, families and staff

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system, that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Involving patients and families: HealthHero recognises the importance of and is committed to, involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the Duty of Candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and/or may have different questions or needs to that of the organisation.

This policy therefore reinforces existing guidance relating to Being Open and Duty of Candour procedures and recognises the need to involve patients and families as soon as possible in all stages of any relevant investigation, or improvement planning, unless they express a desire not to be involved.

Involving staff, colleagues, and partners: It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Involvement of staff, including partner agencies, is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This reinforces existing guidance detailed in HealthHero's Adverse Event Reporting, Investigation and Learning Policy.

HealthHero will continue to promote, support and encourage colleagues and partners to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement. Staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame.

Staff involved in patient safety incidents should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, HealthHero will explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

HealthHero supports this approach to focus resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is recognised that planning needs to account for other

sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that HealthHero plans should reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type

Plans will also be:

- Updated as required and in accordance with emerging intelligence and improvement efforts
- Published on HealthHero's external facing website

The patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response: All staff will be made aware of how to access policies and how to report patient safety incidents as part of HealthHero's new starter induction programme.

On induction into their department, all staff will receive a local induction to include patient safety incident reporting processes. It is the responsibility of managers to ensure that staff are made aware of and comply with this policy.

The Quality and Patient Safety and Clinical Effectiveness teams provide training sessions which covers the patient safety incident reporting and investigation, from a management perspective. Additional training can also be provided by the Quality and Patient Safety Team upon request on a one-to-one basis or group session. This can be tailored to people and team requirements (i.e. incident reporting, incident investigation or generating incident reports).

In line with PSIRF HealthHero has identified key roles and responsibilities to ensure the local and effective implementation of the national patient safety incident response standards. Please refer to the PSIRP section covering roles and responsibilities.

Patient safety incident response plan: The PSIRP sets out how HealthHero intends to respond to patient safety incidents over a period of 12 to 24

months. The plan is not a permanent set of rules that cannot be changed. HealthHero will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing the patient safety incident response policy and plan: HealthHero's PSIRP is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 24 months to ensure our focus remains up to date; with ongoing improvement work, HealthHero's patient safety incident profile is likely to change. This will provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 24 months.

Updated plans will be published on HealthHero's external website, replacing any previous versions.

A comprehensive review of HealthHero's patient safety incident response will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results and reporting data) and wider stakeholder engagement.

8. Responding to patient safety incidents

Patient safety incident reporting arrangements: It is the responsibility of HealthHero to ensure that all incidents and near misses are reported, investigated and actioned to prevent or minimise similar instances in the future.

HealthHero staff use Datix, HealthHero's approved incident reporting system, to report all patient safety incidents.

The process of complying with both internal and external notification requirements for the reporting of patient safety related incidents can be found within the PSIRP and HealthHero's Adverse Event Reporting, Investigation and Learning Policy.

Patient safety incident response decision-making: Any patient safety incident meeting the criteria for a PSII as defined in the PSIRP, will be escalated and reported to the HealthHero weekly Datix Committee who will confirm if the incident fulfils the PSII criteria. The Datix Committee meeting is attended by the Chief Operating Officer, Medical Director, Associate Director of Quality,

Associate Director of Operations, Clinical Leads, Service Leads, and members of the Quality Team.

In circumstances when it is not immediately clear if the incident meets the criteria for a PSII, an appointed lead investigator will undertake an initial review of the incident, liaise with the relevant clinical and non-clinical staff, gather further information and complete an incident review to be presented at the next appropriate Datix Committee.

When potential patient safety incidents are identified through the complaints process, the Patient Experience Officer will coordinate an incident review for discussion and consideration at the next appropriate Risk Committee.

The Datix Committee will be responsible for identifying any themes and emergent issues in relation to patient safety matters.

Responding to cross-system incidents/issues: If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and action.

All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

Timeframes for learning responses: Responses must balance the need for timeliness and the capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

HealthHero will aim to complete all PSIIs within 60 working days of the PSII being confirmed. No PSII should take longer than six months to complete. In rare and exceptional circumstances where there is an external investigation into a patient safety incident, for example the police, HealthHero's PSII will not commence until permission from the external agency has been granted.
Safety action development and monitoring improvement: Where learning from patient safety incident responses identifies the need for safety improvements, these will be recorded on Datix, HealthHero's patient safety management software.

Action and improvement plans will be escalated to HealthHero's Associate Director of Service Improvement and can be monitored through the

organisation's governance committee structure including Quality Committee, Risk Committee and Clinical Effectiveness Committee.

All safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics.

Safety improvement plans: All learning from PSIIs will be recorded on an action plan in the investigation report. A SMART approach to action planning is essential. That is, the actions should be:

- Specific
- Measurable
- Attainable
- Relevant
- Time-bound

9. Oversight roles and responsibilities

When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate improvement, rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g. panels to declare or review Serious Incident investigations). Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.[2]

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs, to meaningful measures of improvement, quality, safety and outcomes for patients. It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI and have individual patient safety responses 'signed off' by commissioners. However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety.

HealthHero is committed to close working in partnership with the local ICB

[2] B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)

and other national commissioning bodies as required. Representatives from the ICB are invited to attend internal Quality and Datix Committees to facilitate the collaborative approach.

Further clarification of roles and responsibilities within HealthHero relating to responses to patient safety incidents are detailed within the PSIRP.

10. Complaints and appeals process

Patient experience and feedback offer learning opportunities that allow us to understand whether our services are meeting the standards we set, the patients' expectations and addressing their concerns. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously, clearly identifying any lessons and using these to improve our service.

Complaint trends and emerging themes are shared throughout the organisation via monthly executive and Integrated Care Board reporting. Complaint themes and learning are discussed at both HealthHero's Risk and Quality committees.

Complaints processes relating to HealthHero's responses to patient safety incidents are detailed within the Complaints Management Policy.

11. Related policies & procedures

- Patient Safety Incident Response Plan
- Adverse Event Reporting, Investigation and Learning Policy
- Complaints Management Policy
- Being Open and Duty of Candour Policy
- Advocacy Policy
- Disciplinary Policy